

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012288	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/02/2014
NAME OF PROVIDER OR SUPPLIER LAMPLIGHT INN OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E WASHINGTON BLVD FORT WAYNE, IN 46802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00145901.</p> <p>Complaint IN00145901- Substantiated, no deficiencies related to the allegations are cited.</p> <p>Survey Dates: April 2, 2014</p> <p>Facility number: 012288 Provider number: N/A AIM number: N/A</p> <p>Survey team: Angela Strass, RN</p> <p>Census bed type: Residential: 139 Total: 139</p> <p>Census payor type: Other: 139 Total: 139</p> <p>Sample: 3</p> <p>Lamplight Inn of Fort Wayne was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00145901.</p> <p>Quality Review 04/03/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE